A STUDY OF PREDISPOSING FACTORS AND THE CASEWORKER'S ROLE WITH FIVE ALCOHOLIC PATIENTS

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

MILDRED DELORES MOORE

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JUNE 1957

ACKNOWLEDGMENTS

The writer is indebted to her parents and also her thesis advisor, Mrs. Genevieve Alston for support and guidance during the preparation of this thesis.

I also wish to express my appreciation to Miss Barbara Baskerville, my second reader and Miss Emily Crowell, Director of Psychiatric Social Service Department, Wayne County General Hospital and Infirmary, for careful checking of my thesis and for their valuable suggestions.

TABLE OF CONTENTS

2 of 36

CHAPTER I

INTRODUCTION

Significance of the Study

Alcoholism is a problem in this country and affects all classes of the community. The fact that the use of alcohol is socially accepted and offers pleasant, though temporary relief from emotional stress, explains its widespread use. Among the drinkers of alcohol, individuals are found who use it to excess and who are dominated by the alcohol. The writer shall refer to these persons as "alcoholics".

> The medical definition of an alcoholic, as distinguished from the social drinker, is one whose drinking harmfully and definitely interferes with one or more of his important life functions. He, himself usually does not recognize the seriousness of this situation or is not able to control his alcohol consumption although he knows its disastrous results.[1]

> Alcoholism can be defined broadly as any drinking which regularly goes beyond the traditional or customary use of alcoholic beverages or beyond the ordinary compliance with social drinking customs, irrespective of causal or accompanying factors associated with such behavior. It also may be more specifically defined as addiction to alcohol as it is observed in periodic or chronic intoxication, in an overwhelming desire or compulsion to continue drinking and in the development of some type of dependency on the effects of alcohol. As the urge to drink becomes uncontrollable and the person becomes dependent on the perpetuation of alcoholic states through repeated intoxication for whatever reasons, alcoholism can be said to be present.[2]

It has been said that therapy with the alcoholic has been hampered because there isn't enough known about alcoholics on which to base treatment. The writer was also interested in knowing in what ways social

---

[1]Harry R. Lipton, "Medical Psychological Aspects of Alcoholism," Alcohol Hygiene, I (November, 1954), 10.

[2]"Alcoholism," Social Work Year Book, 1954.

service tried to help the alcoholic patient meet his needs.

Predisposing factors, which are a part of the fundamental personality organization, are important in understanding the alcoholic patient. Too much emphasis has been placed on drinking and not enough on the causes. It is more important to learn why the individual takes it to excess in the first place than to attempt to restrain him from having it.

> In essence, the treatment of the alcoholic patient is not different from the treatment of any other emotionally disturbed person... Certainly, inferiority-superiority conflicts, extreme dependency needs, demandingness and manipulation, confusion regarding sexuality, guilt, self-rejection, self-destruction tendencies, and low frustration tolerance are common enough in other patients with neuroses or character disorders.[1]

The aim of casework treatment is better psychosocial functioning or adaption. The caseworker's role with the alcoholic patient may be broadly classified into fact-finding, diagnosis and the rendering of service.

Purposes of the Study

The purposes of the study are three-fold: (1) to obtain a better understanding of the genesis of alcoholism by taking into account the interrelationship of environmental influences and personal development; (2) to determine if the case records give evidences of predisposing factors in keeping with those suggested by literature; (3) to learn of the caseworker's role with the alcoholic in helping him to meet his needs.

---

[1]Cathrin M. Peltenburg, "Casework with the Alcoholic Patient," Social Casework, XXXVII (February, 1956), 81.

Method of Procedure

The case study method was used. Social histories, together with social service progress notes relating to the activities of the patient and social worker have provided the source of material which has been used in this study. The case records were reviewed and data were collected according to the schedule[1] set up by the writer.

In selecting the cases to be studied, the files at the Wayne County Consultation Center were checked and those alcoholics who were admitted between January, 1953 and January, 1956 and who were receiving casework service were used in the study. At the time that the files were checked, five cases fell within this scope.

Reading material concerning alcoholism and the role of the social worker was utilized. A referral to theoretical material was made.

Scope and Limitations

No interviews were held, but the study was limited to the reading of case records.

The years, January, 1953 through January, 1956 were used so that the diagnoses of the patients studied would fall within the classifications in the latest diagnostic manual, which was released in 1952.

The patients studied included four Caucasians and one Negro. There were three women and two men, all of whom were Protestants. The ages of the patients at the time of admission ranged from forty to fifty-five. Only two of the patients (females) had one admission.

---

[1] See copy of schedule in appendix, p. 39.

The other three had several readmissions. Four of the patients were on a three-year Convalescent Leave, while one was still hospitalized. All of the patients were common laborers. Two of the patients (females) were widows, while the other three were married.

Books and previous studies on alcoholism from the Detroit Public Library, Wayne County Consultation Center Library and Trevor Arnett Library were used as references; also used were theses at Wayne County Consultation Center, and classroom notes and textbooks.

Participation in a discussion on the causes of alcoholism has provided a minimum of knowledge.

In order to facilitate the reader's understanding of the study, a brief description of the agency setting, where the study was held, is given in the next chapter.

CHAPTER II

THE AGENCY SETTING

Brief History

In Wayne County General Hospital and Infirmary, from which material for this study was gathered, a number of beds were occupied by alcoholic patients. Statistics show that this situation is common throughout the country.

Wayne County General Hospital and Infirmary, which was organized in 1832 is a county owned public institution located in Eloise, Michigan. It has three divisions: Psychiatric; Infirmary, which cares for the infirm, indigent and less disturbed mental patients; William J. Seymour Hospital, which cares for acute medical and surgical cases.

In the psychiatric division of the hospital, many services were offered, all geared toward rehabilitation. The services offered by the social service department were given special consideration by the social workers as this department was the medium through which both social and emotional problems of the patient were met.

The greatest number of patients in the psychiatric division were patients with a diagnosis of schizophrenic reaction. In addition to psychiatric treatment, various other therapies were available to alcoholic patients such as occupational, music, recreational and group.

The physical plant of the hospital was arranged so as to provide comfort for the patients within the hospital setting. The hospital has its own post office, police and fire departments, laundry, bakery, store, greenhouse, farm, auditorium, tennis court and park.

The hospital setting, being a protective one, was one of the ways

of helping the patient make changes, physically, socially and emotionally, which enabled him to make a more satisfactory adjustment upon his return to the community.

All patients who were committed to the hospital were committed by Probate Court. Before an alcoholic was committed, a petition for commitment was filed by the guardian of the patient. (All alcoholic patients have guardians, either a relative or an interested person. If there is no interested person, the court appoints a public administrator. The guardianship remains in force until dismissed by the court at the time of legal confirmation that the alcoholic was no longer addicted.)

Services Rendered by the Social Service Department

The social service department of the psychiatric division was organized in February, 1923. In 1936, the central offices of the department were moved to downtown Detroit where out-patient services, including psychiatric, case and group work were provided for patients convalescing following hospitalization.

Casework services offered by the agency were varied.

The caseworker's role is in part conditioned by the following:

1. The caseworker is dealing with seriously ill individuals.
2. The setting is an authoritarian one with legal and social obligation to prolong hospitalization when the patient's behavior or illness may be inimical to society or to himself; to accomplish rehospitalization of a patient on Convalescent Leave when necessary and wherever possible to maintain contact for three years after he leaves the hospital or until he is legally adjudicated mentally sound.
3. Responsibility for major decisions and plans for the patient and for request for social service activity lies with the psychiatrist and all cases receiving social service treatment are carried jointly with him or his

permission.[1]

The Admission Service at the hospital served as a focal point for the orientation of new patients and their relatives and provided an excellent opportunity for the development of confidence. The social worker explored and clarified the problem for the patient and relatives. The overall function of the Admission Service was to establish a link between patient, family and hospital.

History taking, another important service, had as its purpose, diagnosis and treatment, social planning and teaching and research. At this time, it was determined if future social service activity with the patient or his family was indicated.

There were some cases in which it was desirable that the caseworker remain or become active during all or part of the patient's period of hospitalization. Casework service was then termed in-patient service and was directed to the patient himself or to the members of the family. The goal was to help the patient realize his ultimate capacity for adjustment, whether it was in terms of hospitalization or Convalescent Leave or both. Casework service was also offered to relatives in relation to feelings and difficulties that appeared to be accentuated by the patient's hospitalization or illness. When the needs of the relatives could not be met within the agency's function, referral to an appropriate community resource was offered.

---

[1]Wayne County Consultation Center, "Social Service Department Manual" (Detroit, Michigan, Wayne County Consultation Center, 1954), p. 18. (Mimeographed).

When the patient had improved sufficiently so that his return to the community was being considered, a study was made of the environmental situation to which the patient was to return. This work was continued in what was termed Convalescent Leave Supervision. Major emphasis was upon facilitating the patient's social adjustment in the community through sustaining contacts or service. This service varied from periodic re-evaluation of the patient's adaptation to his environment to other agency contacts when necessary and work with other members of the family on problems related to the patient's illness. It was also the worker's responsibility to accomplish rehospitalization, when necessary, and also to inform the patient of the procedure for legal restoration of his legal rights.

Short term services offered by the social service department included the obtaining of operative, treatment or autopsy permits and evaluations for Family Care.

The hospital utilized the team approach in terms of collaboration with the psychiatrist, psychologist and social worker, in addition to other personnel who worked with the patient. The patient was always the responsibility of the doctor who was assigned to him when he entered the hospital, both while the patient was in and out of the hospital. The worker's assignment with the patient was carried out in collaboration with the doctor.

Since alcoholism is a symptom of a personality illness, an emotional illness or a more serious mental illness, one should attempt through examination to uncover the causes and psychodynamics producing this symptom.

The following chapter will be a presentation of theoretical

material in terms of predisposing factors of alcoholism. There will also be excerpts from the five cases used in the study to illustrate certain points.

CHAPTER III

PREDISPOSING FACTORS OF ALCOHOLISM

"Alcoholics are sick people. An individual can no more help becoming dependent on alcohol than a child can help having a temper tantrum or an adolescent or adult can help developing schizophrenia."[1]

No problem of adjustment of human beings can be attributed to one cause. Every such problem is determined by a multiplicity of causes bound up in the genetic, constitutional and adaptational patterns of the individual in relation to physical, social and emotional stresses.

Alcoholism is one of the most puzzling problems of present-day psychiatry in terms of theory and therapy. To be of aid to the alcoholic, one must first understand that alcoholism is symptomatic of illness in the personality functioning; then, seek to learn about the alcoholic's personality make up and his actual life setting and circumstances.

There needs to be a greater awareness of the emotional factors that are the bases of alcoholism. Miracles can be achieved with the alcoholic's physical problems in just a few days, but if there is no understanding of the emotional problems that prompted the drive toward excessive drinking, easing the pain associated with drinking will have little or no effect on the illness.

The psychopathology leading to alcoholism varies with the

---

[1]Harry R. Lipton, "Alcoholism and the Community," Alcohol Hygiene, I (March, 1954), 12.

> individual alcoholic. It would appear in many instances that the addictive drinker may have been psychologically traumatized very early in life and his personality remained fixated at an early, oral stage of development. Again alcoholism may occur in persons who through the absence of a desirable identification figure never developed a stabilizing super-ego. Lacking in responsibility and ego strength they are closely allied to the character neurotic. Sometimes the periodic drinker seems by his alcoholic bout to be seeking for relief from an overly strict super-ego. In some instances there are presumably unconscious homosexual identifications and tendencies.[1]

On the basis of the foregoing paragraph, it is obvious that an understanding of the psychopathology associated with alcohol can only be obtained by taking into account the developmental organization of the individual personality and its sources of anxiety, which are pertinent to treatment.

Five case records will be examined in the following discussion to determine if they give evidence of early development and family attitudes of alcoholics in keeping with those suggested by literature.

Early Development

Human beings possess a considerable feeling of anxiety, shame and disgust about themselves and often want to forget about their helplessness and needs of childhood. If one is ever going to understand himself adequately, he must take a backward glance and look at what he went through as a child, accept it and do away with the embarrassment associated with it.

The early years of a child's life are the most important in his life for the simple reason that they come first and inevitably

---

[1]Arthur P. Noyes, Modern and Clinical Psychiatry (Philadelphia, 1953), p. 184.

influence all subsequent development. One of the main principles of Freudian theory is that the bases of neuroses and psychoses are laid down in early life.

> The alcoholic has had early life experiences of great deprivation so that he or she grows up feeling insecure and unable to cope with responsibilities. He is an immature personality and seems to have strong oral trends. These grow naturally from the tendency to keep children dependent. Many parents fear that if the child is allowed to be aggressive and curious and has his curiosity satisfied, he will grow up to be a problem in management or will leave parental authority too soon and so he is kept anxious and dependent. This perhaps makes child rearing easier, in the early years at least, but it has its disastrous results to the child's personality.[1]

> The alcoholic is usually a dependent personality and needs continuous support over a long period of time, frequently for years. One of the reasons that people drink to excess is to gratify an oral need and dependency is an oral need.[2]

> The habit of drinking, having something go into the mouth and down the throat, has a great deal of meaning for alcoholics. In infancy, they were warmed and made comfortable by drinking milk and being nursed by the mother. And in the same way that these attentions quieted the anxiety of the infant, so does drinking liquor fulfill the alcoholic's present need.[3]

The writer shall attempt to support this assertion by illustrations drawn from the five cases, also to show adult manifestations of dependency in the patients' marital situations.

> Mrs. A was the oldest of three children. The patient got along pretty well with her mother and father.
>
> Whenever she was confronted with problems, she went to her mother, who tried to help her the best she could. Although the patient was married, her mother allowed her to live with her for years.
>
> The patient's parents lived together for approximately

---

[1] O. S. English and G. H. Pearson, Emotional Problems of Living (New York, 1955), p. 502.

[2] Noyes, op. cit., p. 199.

[3] O. S. English and G. H. Pearson, Emotional Problems of Living (New York, 1955), p. 501.

twenty-eight years, at which time they separated. Mrs. A married at the age of fourteen to a man a great deal older than herself. She separated from him a year or two later and married again at the age of nineteen without obtaining a divorce from her first husband. She remained with this man about seven or eight years. The patient's third marital situation lasted about fifteen years until the death of her mate in 1948.

The last man with whom she lived drank with her. He was a "wonderful person," good to her and ten years older than the patient. The first two were described as "not being much good" and the patient was disappointed that the relationship with the second man did not work out.

Mrs. A was so starved emotionally that she was unable to assume responsibility for her own problems. The patient, during the oral stage, perhaps recognized that her mother could relieve her , when she was uncomfortable, either through nursing or through being overly attentive to her. She learned that her mother's presence gave her pleasurable feelings and relief from discomforts. At the first intimation of any need for comfort, she wished assistance from her mother; therefore, she returned to earlier ways of gratification. She saw her mother, as well as alcohol, as a stimulant to help her endure her problems and she appeared jubilant when utilizing these.

The writer assumes that there was bickering within the home situation which apparently led to the patient's early marriage. Mrs. A did not gain a feeling of acceptance, and like an infant, who wants to be taken care of, to be fed, loved and sheltered, she sought for a solution to these needs outside of her home. Her marriages to men much older than herself indicated a search for a father figure, which she did not find in the first two husbands.

It seems likely that the third husband's attitude of drinking with her gave her a feeling of warmth and closeness as comparable to an infant being nursed.

Mrs. B was the sixth of seven siblings. She was born at home with no doctor or nurse in attendance. She was breast-fed; weaned at fifteen months; walked at one year and talked at fourteen months. The patient was enuretic beyond normal age. During infancy and childhood, she was irritable, fearful, moody, surly, over-active, secretive, rebellious and resentful of discipline.

The patient was often truant from school along with a girl friend. At the age of twelve, she and her friend were institutionalized at a training school and remained there for one year, when she was placed on a farm with some people who adopted her. At the age of twenty-one, the patient visited her family and refused to return to the farm.

For twelve years, Mrs. B lived with innumerable men while traveling around the country in"transciency-alcoholic" status. She was physically abused by men whom she lived with. At the age of thirty-two, she married a man thirty-five years her senior. They lived together for two years during which time the patient used every available dollar for alcohol.

The patient, being the sixth of seven children, is apparently did not receive love and affection from her parents, particularly the mother. It is obvious that the care of the patient depended on the older siblings. Mrs. B's personality traits represented a rebellion against rejection by her parents. Being enuretic represented her determination to receive attention, even if on a fault-finding basis.

The patient's parents' rejection of her was so great that she probably desired to leave home. This is seen in her being truant, which necessitated her being placed in a training school. Her refusal to return to the people who adopted her indicated a continuous longing for love from her family.

There is a carry-over of the patient's dependency need, in later life, through her living with innumerable men. Here is seen a continuous searching for and never finding someone to fulfill her need.

Mrs. C is the oldest of two sisters. She and her sister were always very close. The patient was shy and withdrawn, but would fight her sister's battles. She was a"tomboy". Her mother was a "strict disciplinarian" and boss of the family. She showed no preference between the two siblings; however, the father would praise and buy things for the sister whereas he never bought things for the patient.

At the age of eighteen, Mrs. C married a man nine years her senior. A daughter was born to this union about a year after their marriage.

The patient's daughter is an alcoholic and would beat the patient; however, the patient never complained. She would "spoil" the daughter.

Evidence points to the fact that Mrs. C was rejected by both parents. Her desire for acceptance by her parents and particularly the father was seen through her fighting her sister's battles. She seemed to have the feeling that if she showed love for her sister, whom the father cared so much for , she would probably gain his love. Mrs. C'c dependent desires, though thwarted by her parents, were somewhat met through her sister's concern and sharing things which were bought for her. Through this lack of parental affection, the patient did not successfully pass through the oral stage of development, which meant that the patient was unable to face frustrations alone; therefore, she resorted to excessive drinking.

Mrs. C was orally fixated and attempted to satisfy her child excessively by spoiling her and at the same time, she was apparently withholding gratification because of her own needs. This created in her daughter a need to return to excessive gratification and great hostility against the depriving figure.

Mr. D is the second oldest of four boys. He had a "good" relationship with his siblings prior to coming to the United States. His mother was stern in rearing the children.

The patient was compelled to leave school to work in the linen mills to assist the family economically.

At the age of thirty-three, he was married to a woman, who was the same age as the patient. Their marital relationship was "strained" due to Mr. D's alcohol addiction and frequent disappearance from home.

His health has been poor for the past fifteen years (ulcers). Drinking increased with his poor health symptoms.

The patient, in early childhood, had emotional needs which he could not satisfy himself because of his helplessness; therefore, he had to depend on someone else for satisfaction. Because of his mother's sternness in rearing the children, he was not helped in fighting his discomforts, but

became overwhelmed by them and remained immobile. Mr. D, not having a maternal figure on whom he could depend, had to face inevitable frustrations, which he could not cope with in early development nor in adulthood.

The patient, being compelled to leave school, was forced from his dependent role into an independent role before he had matured to that point.

The case history of Mr. D points out that he had been the victim of ulcers since he reached the age of forty. There is a connection between ulcers and dependency.

"Prolonged frustration of oral receptive wishes results in repression of those wishes which results in hyperfunctioning of gastric juices which results in ulceration."[1]

> If the wish to receive, to be loved, to depend on others is rejected by the adult or frustrated through external circumstances and cannot find gratification in personal contacts, often a regressive pathway is used: the wish to be loved becomes converted into the wish to be fed. This repressed wish to be loved creates a chronic emotional stimulus which has an effect upon the gastric function of the stomach. Gastric juices are poured into the stomach and if the stomach is empty, the juices act upon the intestinal wall and an ulcer appears.[2]

It is apparent that Mr. D did not receive gratification for his oral needs and needs of dependency. His dependent needs were frustrated because he was not given a mother's love. Because the patient was ashamed of his dependency needs, he assumed the responsibility of marriage. Being the head of his household was not strong enough to drive his dependency

---

[1]Classroom notes, Atlanta University School of Social Work. Physical and Emotional Aspects of Illness. June 14, 1956.

[2]Franz Alexander, Psychosomatic Medicine (New York, 1950), p. 104.

out of existence; therefore, he took flight by disappearing from home frequently.

> Mr. E is the oldest of six children, four of whom are living. His mother was a "very gentle", protective, "easy-going" person who managed the family and household adequately.
>
> His father was a stern man, who worked regularly and provided an adequate income for his family except during the depression.
>
> The patient got along well with the family, friends and school authorities and was favored by his mother.
>
> He married at the age of thirty-six to a twenty-two year old alcoholic, whom he courted one year before marriage. He was divorced one year after his marriage as a result of his wife's attentions to other men. The patient's mother explained to him that he was better off without his wife, as she had been difficult to understand.

The writer sees in the case of Mr. E how the mother's attitude toward him fostered his dependency. The patient's mother, in assuming a role of protectiveness toward him, laid down the basis for his dependency. Mr. E, being unexposed to frustrations in early life, in small doses, could not adjust to anxiety and frustrations in later life; therefore, he resorted to alcohol, which apparently soothed his frustrations as milk and the mother's warmth did during the patient's early years of development. He received an overabundant supply of affection from his mother which served as a pacifier for all of his outcries. Like an overprotecting parent, alcohol assured him that everything would be all right.

The patient apparently felt that through marrying someone whose behavior was similar to his (alcoholic) that there would be a mutual understanding between them. His role of being the man of the house was such a great threat to him and his mother came to his rescue as she had done when he was a child. The patient's wife was not like his mother, so disappointment followed.

The work histories of the patients are significant in pointing out evidences of dependency.

> Mrs. A was a hard worker and always did domestic work for three days weekly. She worked steady two or three months at a time, then went on a drunken spree lasting from one to three weeks. Her employer made allowances for her because she was an excellent worker.

Previous mention concerning Mrs. B's habit of traveling around the country in a "transciency-alcoholic" status has been made. She would return home periodically and work as a waitress for two or three weeks.

> Mr. D came to the United States at the age of twenty-one to join his older brother who came earlier. He was employed as a truck driver for a pipe outfitting company for four or five years; manufacturing company for four or five years; maintenance man for a steel company for six years; worked for a landscaping company and held jobs as a dishwasher, janitor and porter. He had a sporadic work history because of absenteeism due to drinking. During the past three years, the frequency of job changes increased. He held a job about three weeks at the most.

> Mr. E left school at the age of fifteen and became employed as a handy man. He worked his way up to becoming a cabinet maker before the company closed in 1929. He worked irregularly at odd jobs and from 1938 to 1942, he worked as a washerman in a laundry. Until the last two years, the patient had been able to be employed steadily and got along well with everyone. He was fired from jobs because of alcoholism.

In the patients' work histories is seen an inability or unreadiness to face independency. Their failures in employment were due to dependence and fear of facing life alone.

Nothing is known about Mrs. C's work history after marriage; however, her work history prior to marriage was not indicative of a dependency need.

> Psychoanalytic investigations have shown that the most important of the repressed impulses released by alcohol is a homosexual one as is illustrated in one instance by the fact that excessive drinking usually takes place only in the presence of the same sex.[1]

Because of the emotional immaturity existing in so many

---

[1]Nolan D. C. Lewis, "Personality Factors in Alcohol Addiction," Quarterly Journal of Studies on Alcohol, I (June, 1940), 30.

excessive drinkers, traceable to a predisposing childhood pattern resultant upon parental overdominance, over-indulgence, and rejection, we frequently uncover a condition which might aptly be termed "latent homosexuality".[1]

Homosexuals may vary in degree from those who merely like the company of their own sex and never engage overtly in physical homosexual behavior to those for whom homosexual activity is everything.[2]

The cruel, severe father and the weak father can cause difficulties in their sons' psychosexual development and analogous maternal attitudes can hamper the development of the little girl. In the face of either parents' cruel, severe attitude, the child is unable to express any antagonism or aggression; therefore, it is suppressed. The same tension arises when either parent is weak. A child cannot express his antagonism to a parent who is so uniformly good to him; therefore, the aggression must be suppressed rather than expressed. Psychically, he becomes either an obsessional neurotic or a passive homosexual personality.[3]

Mrs. A, with an overprotecting mother, found herself hampered in expressing her antagonism. She stated, upon admission to the hospital, that men in invisible suits were watching for her and were out to kill her. Men were putting little things in ladies' privates. Some men whom she knew tried to do this to her the previous night and they had a quarrel. The patient saw men at the windows with guns shortly after this, called the police at a neighbor's house and asked them to bring her to the hospital for protection.

Mrs. A could not express her aggression to her mother because she was so good and overprotecting of her. As a result, she apparently became passive and non-aggressive and attempted to be happy through taking her mother as a love object. This attributed to her homosexuality.

---

[1]Edward A. Strecker and Francis T. Chambers Jr., "Alcohol and Sex," Alcohol Hygiene, I (November, 1954), 27.

[2]O. S. English and G. H. Pearson, Emotional Problems of Living (New York, 1955), p. 519.

[3]O. S. English and G.H. Pearson, Common Neuroses of Children and Adults (New York, 1937), p.56

Mrs. A'S version of incidents leading up to her hospitalization were symbolic of homosexuality. Her statement that men in invisible suits were watching for her and were out to kill her indicated that she felt threatened by the opposite sex. The guns, being symbolic of a penis, were also threatening to her.

It has been mentioned that Mrs. B was enuretic beyond normal age and that she traveled around the country in a "transciency-alcoholic" status. She also had a history of promiscuity.

> Girls who are enuretic have many fears, particularly of men. Their lives are conducted on the principle that they will try in every way to be like boys. They fear to allow themselves to have natural feminine feelings toward men and as part of an attempt to be like boys, they want to urinate like boys. They cannot do so, so they try to express the wish in their sleep and enuresis results.[1]

It seems obvious that Mrs. B's enuresis was a homosexual desire. Consciously, the patient tried to fight this desire through her relationships with several men and her promiscuousness.

> Mr. E's father was a stern man.
>
> The patient got along well with males and felt frustrated in his failure to have children. Sex instruction was obtained from the father and the patient did not have sexual relations until one year before his marriage. He followed his father's instructions to pour cold water upon the organ when it arose. He was agitated when approached about sex and frequently refused to have intercourse with his wife.

Because of Mr. E's father's sternness, it can be understood how the patient's fear of punishment by the father prevented his expression of antagonism or aggression. The patient perhaps learned to guard himself in all ways possible and to submit to his father without reprisal. Rather than be in a competitive role with the hostile and rejecting

---

[1] Ibid., p. 239.

father, he became an ego ideal with his apparently seductive mother and became homosexual. The motivating reason for such a relationship with the mother was perhaps search of acceptance by the father. He apparently felt that his father would be more accepting of him if he were like the mother.

In identifying with his mother, the patient was loved by other men and got along well with males.

Homosexuality attributed to the patient's inadequacy in sexual relationship. Sex instructions from the father indicated the father's attempt to castrate him. Because of this fear of castration or fear that something dreadful would happen to him if he engaged in sexual intercourse, the patient adhered to his father's instructions. As a result, he felt frustrated in sexual relations.

"According to Noyes," alcoholism may occur in persons who through the absence of a desirable identification figure never developed a stabilizing super-ego."[1]

> The beginnings of the super-ego lie in the deprivations which the parents and others impose on the child'd id impulses; however, the most important source is the solution of the Oedipus complex. The child hates the parent of the same sex for his competency and rivals with him for the possession of the parent of the opposite sex. As a result of this hatred, the child fears that something will happen to him and he also loves the parent of the same sex passionately. The child resolves the pain of this conflict of strong and opposing feelings by taking in and making part of his own psychic apparatus-the psychic image of his hated, feared and loved parent of the same sex. This introjected image stands as a taboo against acting out his wishes to murder the parent of the same sex and his incestuous sexual desires towards the parent of the opposite sex.[2]

---

[1] Op. cit., p. 184.

[2] O. S. English and G.H. Pearson, Emotional Problems of Living (New York, 1955), p. 147.

"The super-ego causes the child to govern his behavior through moral principles and begin to feel guilty if he violates his codes and inferior if he does not live up to them."[1]

Although evidence points to the fact that the parental relationships in the cases of Mrs. A, Mrs. C, Mr. D, and Mr. E were not harmonious, parents of the same sex as the patients were in the home, so that there was an opportunity for each of the patients to have an identification figure. None of the patients successfully passed through the Oedipal phase of development.

At the end of two years of marriage to Mrs. B's mother, her father deserted the family. Mrs. B did not pass successfully through the stage of the Oedipal conflict because her father was out of the home during her Oedipal phase of development. As a result of the father's absence, no castration threats were present, so the patient did not have to identify with the mother in order to meet these threats. In this instance, Mrs. B did not develop a stabilizing super-ego.

Family Attitudes

> Moderation in habits is best taught at home. Alcoholics are rarely found in families where the attitude toward drinking has been sound and healthy from a mental hygiene point of view. Alcoholics are commonly recruited from two types of families: those in which drinking is encouraged as an end in itself and those in which drinking is vehemently forbidden. Members of families in the former type readily become habituated. In such families the individual reaches for another drink as casually as he reaches for another cigarette. The individual may thus as easily become a chain drinker as another member of the family may become a chain smoker. We need only to look about us to see the results of rigidly forbidding drinking in the home. Where family ties are unusually strong, the members well adjusted to each other and the home a most happy one, this

---

[1] Ibid., p. 148.

approach to the problem may be successful. Most adolescents, however go through a period of rebellion against real or fancied mistreatment by their parents. If they come from homes in which alcohol is aggressively prohibited, they frequently resort to excessive and uninhibited drinking as a retaliatory measure against their parents. Members of such families, in asserting their independence, in attempting to develop their individual personalities, and in rejecting the outmoded mores of a past generation, are predisposed to go to extremes, particularly in the use of alcohol.[1]

According to Bigelow and his workers,"an alcoholic family background is not infrequent."[2]

Material in the case records of Mrs. A and Mr. E did not give family attitude in relation to alcohol.

Mrs. B's paternal grandmother was heavily alcoholic and quite promiscuous. Her father was also a long time chronic alcoholic.
The patient's mother was hated by all of her father's relatives because she would not drink and carry on. Seeing the patient upset the mother.

Mrs. C's father was happy-go-lucky and a heavy consumer of alcoholic beverages.
Her mother disapproved of the father's drinking; however, a few years after his death, she married a man who was happy-go-lucky, an excessive drinker and thirteen years her senior, as was her first husband. The patient and her step-father would drink together and he would purchase liquor for her.

Mr. D's father was a devout Catholic and was firm in his belief of the Catholic religion. The patient's mother was heavily addicted to alcohol.

Excerpts from the cases of Mrs. B, Mrs. C and Mr. D show the family predisposition to alcoholism. It can be seen how the three patients followed the course of excessive drinking as it existed in one of the parental figures in each case. Through knowledge of the parents'

---

[1]Harry R. Lipton, "Alcoholism," Alcohol Hygiene, I (March, 1954), 12-13.

[2]Lewis, op. cit. , p. 36.

drinking or perhaps seeing them drink, the patients probably felt more at ease in assuming such a trait. This was open encouragement to them and a pattern or guide for them to follow.

The patients' mothers' disapproval of drinking in the cases of Mrs. B and Mrs. C was seemingly influential in causing them to become alcoholic. Their drinking served as a rebellion against weak family relationships and perhaps meant attention for them.

Drunkenness is always more acceptable than a psychosis and for this reason, one finds a great number of alcoholics who drink to relieve their overwhelming, unpleasant stresses. The nature of this will be discussed in the following chapter.

CHAPTER IV

DIFFICULTIES PRECIPITATING ALCOHOLISM

> Psychological knowledge and experience show that a practice so universal as that of the use of alcohol must exist because it satisfies some deeply seated psychological need. This need, it often appears, is for relief from the tensions which have been induced by anxieties, frustrations and conflicts. Anxiety is such a constant and universal experience of mankind and alcohol is so effective in alleviating it that its use has become very wide.[1]

> The alcoholics' conflicts are so numerous and so near the surface that he could not face his conflicts unless he resorted to alcohol. The crushing nature of his early environment is chiefly responsible for the fact that the conflicts are so close to the surface, that he is too extremely sensitive to anxiety and any type of psychic pain.[2]

Alcohol may be used as an escape from painful life situations, as domestic and economic worries, loss of job, social stresses, an escape from physical pain and from grief, as the result of the death of a loved one. The excessive use of alcohol seems to bring the individual into a more comfortable state of endurance toward frustrations along these lines.

> Alcohol promotes social feeling but aids the individual in repression of mental conflicts. Alcohol may either serve as a pacifier for physiological and psychological tensions enabling the individual to flee from an unpleasant situation, or it may be taken to increase function in order to aid in meeting a situation. Thus in psychological terms it promotes compensation or defense.[3]

---

[1] Noyes, op. cit., p. 183.

[2] Isidore Portnoy, "Psychology of Alcoholism," Alcohol Hygiene, I (March, 1954), 16.

[3] Lewis, op. cit., p. 37.

Turning from theoretical expectations to the patients in the study, do these patterns appear in the cases?

> Mrs. A had been drinking for about twenty years with very little change in amount or frequency. Her drinking began during her disillusionment over the break of the relationship with the second man with whom she lived.
>
> She had periodic drunken sprees lasting from one to three weeks. During this time, she ate very little and slept occasionally. She drank at bars and sometimes at home. She talked irrationally for a week following drunken sprees. For three or four months, the patient did not drink at all and was completely a different person. Prior to her drunken periods, she seemed a little depressed, talked about the death of various family members and offered these as reasons for her taking a drink.

> Mrs. B had been an alcoholic for twenty years. The patient had minor epileptic seizures prior to being institutionalized in a training school when she was twelve years of age. While there she, along with several other girls, was sterilized. Shortly thereafter, she had epileptic seizures preceding menses, which is said to have accentuated her alcoholism.

> Mrs. C's sister felt that the patient's drinking began in an effort to ease menstrual cramps. She had been drinking for a period of twenty-two years. Her drinking began a few years after her marriage and was then confined to bars, but, lately the patient had been drinking at home. Her husband disapproved, but did not object because she said that it made her feel better.
>
> The patient's mother's and daughter's illnesses (Mother had cancer of throat and daughter had lump on her spine) upset her a great deal and she resorted to drinking.

> Mr. D had been an alcoholic for twenty years off and on, continuously during the past three years. His health had been poor for the past fifteen years (ulcers) and his drinking increased with his poor health symptoms. He drank mostly in beer gardens in the company of others, followed by drinking in his home.

> Mr. E always drank moderately, but began excessively after the death of his mother about two years before his hospitalization. His father died approximately four years before his mother's death. Within four months after his father's death, his younger brother also died. The patient was extremely fond of his mother and "he went down continuously after her death".

The above illustrations show that the patients resorted to alcoholism because of stresses due to marital difficulties, deaths of loved ones, physical pain and family illnesses. Because these individuals were

emotionally dependent and immature, their tolerance for anxiety and frustration was low; therefore, they resorted to excessive drinking to blot out reality and as an easy means of relief. They learned that drinking was effective in quieting the maladjustments that made life uncomfortable and unbearable.

> The alcoholic is like an individual with an immense big toe which is constantly being stepped on. He is constantly feeling hurt, abused, disappointed, indignant. He walks about with feelings of tremendous hostility and resentment, which, however, he is unable to express openly because of his own needs for affection and because of his fear of retaliation. Under alcohol, the hostility does find expression.[1]

> Every alcoholic is an immature, insecure, oversensitive and anxious person who is suffering from marked feelings of inferiority, unable to meet and enjoy people socially or unable to get on with his work without the support of alcohol in fairly large quantities. Too many people need alcohol to produce friendliness and a state of mind suitable for social intercourse or for carrying on their work. These people are not fundamentally mature enough or friendly enough to carry on these functions without alcohol.... The drink produces a pleasant senation within and they feel emotionally warmer toward each other.[2]

Although the five patients in the study were receiving casework service, they were not under intensive treatment. Their main need was for understanding and support. The following chapter will point out the caseworker's role in working with the patients.

---

[1]Portnoy, op. cit., p. 18.

[2]O.S. English and G.H. Pearson, Emotional Problems of Living (New York, 1955), pp. 500-501.

CHAPTER V

THE CASEWORKER'S ROLE WITH ALCOHOLIC PATIENTS

Certain characteristics of the alcoholic patient must be understood in order for the caseworker to work with him.

> Because of the particular nature of the alcoholic's emotional problems, the treatment of these patients calls for certain modifications of techniques. The alcoholic's guilt, discouragement, and anticipation of failure and rejection necessitate a more active approach than the usual passive, receptive one. Mere "interested" listening is not enough. The caseworker must work to establish quick rapport and a feeling of trust on the patient's part if he is to keep him as a patient. There are several ways in which this can be achieved.
>
> To counteract the alcoholic's feeling that no one but an alcoholic can understand his problem, we must make it clear that we recognize that his drinking is beyond his control and that we know that he is suffering mentally, morally, and physically. We must let him know we understand how strong his need to drink must be, since it outweighs the serious consequences of which he himself is aware - possible arrests, debts, and loss of wife, home, and self-esteem. It is also extremely important to be alert to, and to hunt for, signs of achievement, such as a good work record; for instance, the fact that he has merited respect from a boss who always takes him back. Commenting on such facts and giving the patient recognition for his achievements offer a means for establishing rapport and have the additional value of reawakening extinct self-esteem. To an utterly discouraged person, the rekindling of self-respect is the first step toward recovery.
>
> Helping the patient to build self-confidence and self-tolerance is the most important aspect of treatment. To bring this about, a positive relationship between patient and caseworker is essential. Since the alcoholic patient cannot tolerate his own aggressiveness and anger, he needs the emotional support of the caseworker while he experiences these frightening emotions. If such support is given and maintained, the patient gains confidence in himself and he is enabled, despite his unconscious machinations to bring about his rejection, to remain in treatment and to develop gradually more tolerance of his negative feelings.
>
> Another difficulty in treating the alcoholic arises from his tendency to isolate his drinking from his psychic life. Many alcoholics are inclined to regard their drinking as a mysterious foreign body, unrelated to their feelings and experiences, and as something entirely beyond their control.... The unperturbed caseworker can combat this attitude by questioning the patient about the onset of his drinking and about his relationships with others at that time. He can convey to the patient that he actually does drink to produce some effect; for example, to be more at ease with a girl friend or to ameliorate his feelings of depression. Such interested questioning tends to set him

thinking about himself and to help him participate in the therapeutic process.

In the early phase of treatment, some concessions must be made to the patient's demanding attitudes. When specific demands cannot be granted, the caseworker must be "giving" in another area in order to prevent the patient from feeling rejected and to mitigate the anger and disappointment he experiences when he is frustrated. His reactions should be dealt with at once so that he will not disrupt the therapeutic relationship.

Differences between the approach used with the alcoholic and with the usual neurotic patient diminish and even disappear after treatment has progressed to the point that the alcoholic has developed greater tolerance for frustration, has lost some of his fear to face himself, and has gained greater self-confidence.[1]

Techniques common to all social workers are used in all fields: Study of client and social conditions that surround him; analysis of such data; use of all available resources upon which the client can draw for employment, recreation and medical care and the aid given the client to better utilize his own abilities.

Home visits, talks with relatives and social and recreational contacts with the client provide opportunity for observation and further acquaintance. Interviews provide opportunities for the client to express himself freely and through such expression to recognize his own problems and attitudes and the basis for them. In interviews, the worker uses methods common to social relationships generally---giving reassurance, interpretation, advice, using persuasion, or, in certain situations, refraining from all such methods. All these things make up a common reservoir of casework techniques.

As a member of a staff made up of a psychiatrist, social worker and a psychologist, the psychiatric social worker is concerned with the treatment of the patient's social situation. In general, her task involves a four-fold function: First, she analyzes the patient's social situation in relation to his present difficulty; such analysis is based upon a study of conditions in his home, family and neighborhood and his attitude toward them, and is utilized, with the psychiatric, physical and psychological findings, in diagnosis and treatment. Second, she interprets to the family the patient's problem and the recommendations made by the psychiatrist, always keeping in close touch with changing conditions in the home and family life which may cause an adaptation in plans. Third, she aids the patient and his family to work out a program for a more adequate social adjustment, working closely with the psychiatrist as treatment progresses. And, last, she interprets the diagnosis and plans for treatment to her co-workers or to members of other social agencies who may also be interested in the client and his family.[2]

---

[1] Cathrin M. Peltenburg, "Casework with the Alcoholic Patient," Social Casework, XXXVII (February, 1956), pp. 83-85.

[2] Lois M. French, Psychiatric Social Work (New York, 1940), pp. 2-3.

Casework with the patients in this study was to help them to make a more satisfactory adjustment to reality situations and to deal with their social and emotional problems of everyday life.

For purposes of this study, the writer shall focus the caseworker's role on fact-finding, diagnosis and rendering service.

All of the patients in the study, when admitted to the hospital were seen by a social worker, who obtained a history of the patient's drinking. After admission, a worker was assigned to each case to secure the social history from members of the patient's family and/or friends. The social histories were taken for diagnostic purposes. The worker gathered information to assist the psychiatrist in bearing out his diagnosis, also to diagnose the social situation. This served as a basis for determining the feasibility of the patient returning to his home when Convalescent Leave was recommended.

> The worker explained her function to the patient's(Mrs. A's) sister. She inquired if the patient's presence in the home would create any problems to her, also if it would be possible for the patient to obtain a job. The sister felt that getting a job would not be difficult because of the patient's excellent work record prior to hospitalization.
>
> The worker explained Convalescent Leave and hospital supervision to the patient, but the patient felt there was no need for social service as her family was able to help her with any problems that she had. The worker explained to the patient that she would continue to see her as it was regular hospital procedure. Mrs. A was fearful of the worker interfering with her job possibilities; therefore, the worker explained her function and role, pointing out that it was neither her purpose nor intent to call at the homes of her employers as she seemed to think and damage her relationship with them. The patient then relaxed and talked about jobs that she had, the death of her parents and personal things.
>
> Mrs. A was given support and encouragement in seeking a job. She was referred to the employment office because she had difficulty in finding a job. Reassurance was given to the patient that she was able to work productively and was a worthwhile person.

No doubt, the patient's sister was anxious in relation to her contact

with the worker; therefore, in an attempt to alleviate some of the anxiety, the worker explained her role. More important than anything else was the warm interest that the worker showed in the sister's welfare, as well as the patient's, through her inquiry as to whether the patient's presence in the home would create a problem, also inquiry as to a job for the patient.

Realizing Mrs. A's need for guidance and someone to hold on to, the worker expressed her interest in the patient and her desire to help her cope with environmental problems. Mrs. A was apparently frightened of the outside world and needed to discover that there were others, besides her family, who were interested in her. The worker's explanation that the hospital would not interfere with her job, placed the patient in a better position to accept the worker and convince her that her situation was understood.

The worker attempted to bring about a reduction of the patient's anxieties by encouragement and support of her strengths. Assistance was given to her in making plans to find employment. The comment made on Mrs. A's ability to work and her worthwhileness was realistic and appreciative. It helped to bolster her confidence in herself.

> The worker, in the case of Mrs. B, made several visits at intervals to the home of the patient's sister prior to Convalescent Leave. Explanation was given to the sister in reference to the patient's course outside of the hospital while the patient was on Convalescent Leave. The patient expressed a desire to work, so a suggestion of employment in a greenhouse or flower shop was made, preferable to the care of a home as the patient objected to the latter.
>
> Mrs. B was referred to the employment office and was also encouraged to file applications at stores.

In visiting the sister's home prior to Convalescent Leave, the worker's aim was around helping the patient with plans toward moving back to the

community, also to assist the patient's sister in understanding the patient and her needs, thereby preparing the sister for perhaps happier living with the patient.

The worker picked up the fact that Mrs. B's sister might be under tension from the combination of the patient's illness and the Patient's returning to live with her. Her explanation of the patient's course outside the hospital seemingly served as a release inasmuch as it gave the sister the assurance that she could rely on the worker and the psychiatrist for help with the patient.

The worker let the patient know that her difficulties in obtaining a job were understood. This was seen through her referral of the patient to the employment office. The patient's strengths were recognized and she was permitted to have responsibility in job-finding.

> Several visits were made to the home of Mrs. C prior to Convalescent Leave. The patient was a diabetic and the worker made arrangements for her to return to the hospital for treatment for her diabetic condition.
>
> After the treatment course ended, the patient returned home on Convalescent Leave. The worker made several visits to her home to evaluate the home situation and observe how the patient was getting along.

Here is seen an exploration of the home situation to which the patient is to return in order to determine the feasibility of the patient returning there. These visits also served to acquaint the relatives with the patient's condition and to determine the reactions and possible effect upon those with whom he would be associated. The overall purpose of these visits was to make the Convalescent Leave period as constructive as possible to all concerned.

The worker, being interested in Mrs. C's total adjustment, arranged for her to be returned to the hospital for treatment of a medical condition.

The worker's continued interest in the patient's adjustment was seen through her numerous visits to the patient's home to evaluate the home situation and to determine how she was getting along.

> The hospital rules were interpreted to Mr. D and his wife.
>
> Support was given to the family in view of the patient's hospitalization and in continuing his ward adjustment. He was given clarification as to his doctor notifying him when he was eligible for Convalescent Leave. He was told that when released, the worker wanted him to go to work to relieve the pressure placed on his son, who had full responsibility. The patient stated that he was in accord.
>
> Mr. D was placed on several jobs by the employment office, but did not keep any of them; therefore, he was reluctant to return to the employment office in search of subsequent jobs. The worker explained to him that she understood his condition and that she would continue to try to help him. The patient obtained employment and worked well until he began to drink excessively and his aggressive behavior necessitated his return to the hospital. The worker gave assistance to the patient's wife in returning him to the hospital through the police department.
>
> The worker remarked to the patient that she was willing to cooperate with him in doing everything possible to make it convenient for him on the ward and that she understood his case. She explained to him that she thought it best that he cooperate with the personnel on the ward as much as possible before making a lot of requests for special privileges, such as ground privileges and a job.
>
> The worker explained the policy to the patient that since he was readmitted to the hospital by warrant, it would be six months before he would be eligible for Convalescent Leave. He was told that he could not return to his last job because of the different stories told to his employer.

Again, the worker interpreted the hospital rules in an effort to help the patient and his wife accept hospitalization. The worker's contact with the patient indicated that Convalescent Leave was not too far in the future.

The worker assumed an authoritarian role in telling the patient that she wanted him to go to work when released.

> Sometimes, in spite of the efforts made to help the patient make an adjustment outside the hospital, his symptoms recur. It is then the caseworker's task to try to help him return to the hospital willingly or to aid his relatives in helping him to do so. Frequently the caseworker is successful in accomplishing this. If it is not possible, then his relatives must enlist

the help of the proper law enforcement officials.[1]

Because of the difficulty experienced in returning the patient to the hospital, the worker gave assistance to his wife by referring her to the proper agency.

Understanding and acceptance was given to the patient in view of his having to return to the hospital. The worker's suggestion that Mr. D cooperate with the ward personnel as much as possible before requesting special privileges was made to assist him in overcoming his weaknesses by making feasible steps toward attaining a well-adjusted life.

The worker's willingness to help Mr. D obtain employment indicated interest in the patient.

> The worker visited Mr. E's brother and in discussing future plans for the patient, he expressed his feeling that it was most advisable to place the patient away from home because of difficulties around alcoholism and his associates. It was felt that placement on a farm was most acceptable.
>
> The worker accompanied the patient in looking for a job on several occasions, but he allowed the patient to carry a good deal of the planning involved in working. He was permitted to take the initiative in job-finding.
>
> The worker continued to express interest in helping Mr. E to find work and to maintain himself on the outside. He continued to make it possible for him to look for work.
>
> Mr. E was unable to secure employment; therefore, the worker attempted to obtain relief for him from the Department of Social Welfare and because this did not work out, he arranged for temporary readmittance of the patient to the hospital.
>
> The patient was given clarification as to the doctor's role in planning Convalescent Leave for him.

In discussing Convalescent Leave, the worker wisely pointed out the best possible living arrangement for Mr. E. He was frank in telling him what he thought would be best for him. The worker evidently felt that

---

[1]Charlotte Sabat, "The Mental Patient Released on a Trial Visit," Social Casework, XXXVIII (February, 1957), 84.

he had a good enough relationship with the patient to discuss with him the reality of living outside his home.

The worker's assistance with job-finding contained elements of acceptance, yet he recognized that the patient could share in his own planning; therefore, he permitted the patient to have as much responsibility as possible.

The patient perhaps gained a feeling of acceptance through the worker's attempt to obtain financial aid for him and ultimate rehospitalization, which would assure him of proper care.

The following chapter will present a summary of the foregoing chapters.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The purposes of this study were three-fold: To obtain a better understanding of the genesis of alcoholism by taking into account the interrelationship of environmental influences and personal development; to determine if the case records gave evidences of predisposing factors in keeping with those suggested by literature; to learn of the case-worker's role with the alcoholic patient in helping him to meet his needs.

The study utilized five cases. All alcoholic patients who were admitted to Wayne County General Hospital between January, 1953 and January, 1956 and who were receiving casework service were used in the study.

Through the use of a schedule, data were abstracted from individual case records. Information in the case records varied in length and comprehensiveness.

Alcoholism is a problem in this country and is one of the most puzzling problems in terms of theory and therapy. The main focus of the problem lies in finding the answer to why the individual takes alcohol to excess. This can only be seen through a study of the genetic, constitutional and adaptational patterns of the individual in relation to physical, social and emotional stresses, and are termed predisposing factors.

The findings of the study seem to support theoretical material in terms of predisposing factors of alcoholism. Early development and family attitudes toward excessive drinking were significant in the study.

The findings were as follows: (1) Each patient showed extreme dependency, need of acceptance, approval and affection; (2) Evidences of homosexuality were seen in three of the patients; (3) None of the patients successfully passed through the Oedipal phase of development, which means that none of them developed a stabilizing super-ego; (4) One parent in three of the cases was heavily addicted to alcohol; (5) Alcohol was used as an escape from situations of life which the alcoholic could not face; (6) The case worker's role with the patients was mainly one of understanding and support; however, help was offered in a variety of ways: fact-finding; diagnosis; convalescent leave planning; job referrals; encouragement of self-help; acceptance of the patient in view of his illness; helping the patient and his relatives gain awareness of his limitations and strengths; rehabilitating the patient to the community, and follow-up of the patient while on Convalescent Leave.

APPENDIX

SCHEDULE

I. Identifying Data

A. Age

B. Sex

C. Marital Status

D. Race

II. Early Development Data

III. Family Attitudes Toward Drinking

IV. Factors Related to Drinking

A. Length of time patient had been drinking

B. Nature of drinking sprees

C. Domestic stress

D. Economic stress

E. Physical illness (Personal and family members)

F. Depression as a result of death in the family

G. Social stress

V. Evidences of the Caseworker's Role

A. Fact-finding

B. Diagnosis

C. Rendering of service

BIBLIOGRAPHY

Books

Alcohol, Science and Society. New Haven: Journal of Studies on Alcohol, Inc., 1945.

Alexander, Franz. Psychosomatic Medicine. New York: W. W. Norton and Company, 1950.

Alexander, Franz, et. al. Dynamic Psychiatry. Chicago: University of Chicago Press, 1952.

_____. Psychoanalytic Therapy. New York: The Ronald Press Co., 1946.

Burton, Arthur and Harris, Robert (editors). Case Histories in Clinical and Abnormal Psychology. New York: Harper and Brothers, 1947.

Cockerill, Eleanor E. A Conceptual Framework for Social Casework. Pennsylvania: University of Pittsburg Press, 1952.

English, O. S. and Pearson, G. H. Emotional Problems of Living. New York : W. W. Norton and Co., Inc., 1955.

_____. Common Neuroses of Children and Adults. New York: W. W. Norton and Co., Inc., 1937.

French, Lois M. Psychiatric Social Work. New York: The Commonwealth Fund, 1940.

Hamilton, Gordon. Theory and Practice of Social Casework. New York: Columbia University Press, 1951.

Hollis, Florence. Women In Marital Conflict. New York: Family Service Association of America, 1949.

_____. Social Casework in Practice. New York: Family Service Association of America, 1939.

Kasius, Cora. Principles and Techniques in Social Case Work. New York: Family Service Association of America, 1950.

Kurtz, Russell H. (ed.),. Social Work Yearbook. New York: American Book-Stratford Press, Inc., 1954.

Lowery, Lawson G. Psychiatry for Social Workers. New York: Columbia University Press, 1950.

Noyes, Arthur P. Modern Clinical Psychiatry. 4th Ed. Philadelphia: W. B. Saunders Co., 1953.

Preston, George H. Psychiatry for the Curious. New York: Farrar and Rinehart, Inc., 1940.

Articles

Lewis, Nolan D. C. "Personality Factors in Alcohol Addiction, " Quarterly Journal of Studies on Alcohol, I (June, 1940), 21-42.

Lipton, Harry R. "Alcoholism and the Community, " Alcohol Hygiene, I (March , 1954), 11-13.

_____. "Medical Psychological Aspects of Alcoholism, " Alcohol Hygiene, I (November, 1954), 10-14.

Peltenburg, Cathrin M. "Casework with the Alcoholic Patient, " Social Casework, XXXVII (February, 1956), 81-85.

Portnoy, Isidore. "Psychology of Alcoholism," Alcohol Hygiene, I (November, 1954), 15-21.

Sabat, Charlotte. "The Mental Released on a Trial Visit, " Social Case-Work, XXXVIII (February, 1957), 81-86.

Sapir, Jean V. "Relationship Factors in the Treatment of the Alcoholic," Social Casework, XXXIV (July, 1953), 297-303.

Strecker, Edward A. and Chamber, Francis T. Jr. "Alcohol and Sex, " Alcohol Hygiene, I (November, 1954), 25-28.

Unpublished Material

Wayne County Consulation Center. Social Service Department Manual, Detroit, Michigan: 1954 (Mimeograph).

Classroom notes, Atlanta University School of Social Work. Physical and Emotional Aspects of Illness. June 14, 1956.